University Eye Center
FERRIS STATE UNIVERSITY

Referral to UEC Pediatrics & Binocular Vision Service

Patient Name _____ **DOB** _____

Parent/Guardian Name _____

Patient Phone Number_____ **Referring Physician** _____

Office Name _____

Address _____

Office Phone Number_____ **Fax** _____

Would you like us to call and schedule your patient? ☐ **Yes** ☐ **No**

Reason for Referral (check all that apply):

Visual Efficiency Evaluation
- ☐ Strabismus
- ☐ Amblyopia
- ☐ Accommodative Disorder
- ☐ Vergence Disorder
- ☐ Oculomotor Dysfunction
- ☐ Other Binocular Dysfunction

Special Population Exam
- ☐ InfantSEE
- ☐ Special Needs
- ☐ Impaired communication

☐ **Vision Therapy**

Visual Information Processing Assessment
- ☐ History of Dyslexia or IEP
- ☐ General reading difficulty
- ☐ Other school difficulty_____

☐ **PEDIG Study**

Referral to Include:

☐ **Evaluate and consult** ☐ **Evaluate, treat, return for primary care** ☐ **Assume responsibility of care**

Refer To:

☐ **First Available**
- ☐ Dr. Alison Jenerou
- ☐ Dr. Paula McDowell
- ☐ Dr. Mark Swan
- ☐ Dr. Avesh Raghunandan
- ☐ Dr. Dan Wrubel
- ☐ Pediatric and Binocular Vision Resident
- ☐ Other _____

Please fax last comprehensive exam and any additional information, comments, or concerns to (231) 591- 3991, **Attn: Kerrie Currie**

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